PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING _				20/2023
	ROVIDER OR SUPPLIER	ARE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 600 SS=J	is not in compliance verification to the following deficie investigation of compliant will be sent to the faciseparate cover.  Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation The resident has the eneglect, misappropriation and exploitation and exploitation as definited but is not limic corporal punishment, any physical or chemit treat the resident's mediate with the selection of the facility of the	pecialty Care Nursing Home with 42 CFR Part 483 gram Care Facilities due encies written during the faints #116629-A and do November 6, 2023 to  ts #116629-A and 116630-A lity at a later date under  Neglect  Manage Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  If y must-  Everbal, mental, sexual, or oral punishment, or  is not met as evidenced  ord review, law enforcement y policy review, resident and	Fé	600			
	staff interviews, the fa residents safe from se	exual abuse and financial					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		165323	B. WING		C 11/20/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 600	Resident #1 reported (CNA) forced her to perform the common transferred money from the electronic money transferred money from the facility and the electronic money and the facility provided in the facility in the facility in the electronic money from the facility intervies and oriented resident the facility audited the non-verbal signs of a common the facility update the checklist to include the facility to the facility to the common the facility to the facility update the checklist to include the facility to the facility the facility the facility that the facility is the facility that the facility that the facility the facility that the fac	residents (Resident #1). If a male Certified Nurse Aide perform sexual acts on him. If a cNA and another CNA on her account using an insferring service. Despite the abuse from the male CNA to lity failed to prevent him from allnerable residents in the  formed the facility of the (IJ) that began as of at 4:00 PM. The facility decreased the scope to a "D" following actions: at abuse and sexual abuse live. non-consensual and to immediately report the 3. If Elder Abuse to include a con 11/10/23. If Elder Abuse to include a con 11/10	F 6	00	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		165323	B. WING	B. WING		C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	•	11/23/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Interview for Mental indicating intact cogr reflected that Reside Resident #1 required person for transfers, personal hygiene. The frequently incontinent continent of bowel. To f disorder of the kid hypertension (high be mellitus, anxiety, dep Stress Disorder (PTS of upper lobe (lung of indicated that Reside pain.  The Care Plan included that Reside pain.  The Care Plan included that Reside pain.  The Care Plan included that Reside to the community.  B. Activities of daily I Interventions directed independently proviouse, and transfers.  C. Resident #1 is ind. Interventions reflected front wheel walker.  The Discharge Summ 12:00 PM, reflected to Resident #1 to a hore.	um Data Set (MDS) (24/23 identified a Brief Status (BIMS) score of 14, nition. The assessment ent #1 did not have behaviors. I limited assistance from one dressing, toilet use, and ne MDS listed Resident #1 as at of urine and always The MDS included diagnoses ney, heart failure, lood pressure), diabetes pression, Post-Traumatic SD), and malignant neoplasm encer). The assessment ent #1 almost always had  ded the following Focuses and the following Focuses are for following Focuses and the following Focuses are for following Focuses are for following Focuses and following Focuses are for following Focuses are f	F 60				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165323	B. WING		11/20	/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	, 17726	72020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	allegations of sexual her time as a resider I, CNA, sexually abut while taking care of I kiss her inappropriat and on her feet. She her discharge, she whave a cigarette and asked if she would li car and she agreed. and while in the vehi oral sex on him. She small red car parked highway.  On 11/14/23 at 2:15 interviewed Residen as forthcoming but vehicle and had diact. She mentioned while at the facility a She told the officer to explicit video of hims.  On 11/6/23 at 2:13 F when she reported her members, somehow around. Due to this side the facility any more Administrator came yelling, and told her because the staff represexual favors for cigistaff took her outside shared with a couple	viewed Resident #1 about abuse. She said that during in the nursing home, Staff sed her. She stated that her, Staff I would touch and ely on the back of the neck said that 2-3 weeks prior to vent outside the facility to it had been raining. Staff I ke to have her cigarette in his He wheeled her to the car cle, he forced her to perform a described the vehicle as a by the row of trees near the  PM, the Police Officer who that a the said that when what happened, she fficulty describing the sexual being heavily medicated and could not give consent. That Staff I sent her a sexually self.  PM, Resident #1 said that the are abuse to a couple of staff, they twisted the story she did not trust anyone at	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	l	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	perform oral sex on her nice and spent tis she may have gave when she sent him to video of him pleasur.  When asked to shar for the investigation, the video of a male in revealed that Staff I addition to the text to phone included the to account to Staff I's CO on 11/15/23 at 2:20 she took a lot of pair that made her mindicular on the actual downward that Stavideo after the incident transfer because he when he had her in the messages between confirmed that Staff 10/12/23). Resident very safe with Staff I an interest in her, and Even though she confide pendently, he whelp her with things, her bedding after be confused her, she did would do that kind on interest in her. One to nightgown that had a neckline. He tied the on the neck without	to his car and made her him. She said that he treated me with her. She thought that him the wrong impression exts. He then sent her a ing himself.  The the sexually explicit video on 11/9/23 Resident #1 sent masturbating. The phone sent it from his phone. In ansactions, Resident #1's ransfer of money from her cash App on 10/16/23.  The Resident #1 said that a medications at the facility, fuzzy, and she could not be attent of the incident. She aff I sent the sexually explicit ent, but before the Cash App told her about the video he car (A screenshot of text Staff I and Resident #1 I sent the explicit video on #1 said that initially, she felt and the incident and the car with her, took in the spent time with her, took in the said that her room and she said that he changed	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			(	c	
		165323	B. WING				20/2023	
	ROVIDER OR SUPPLIER	Y CARE	•	1116 EAST HIG	ESS, CITY, STATE, ZIP CODE BHWAY 20 NVILLE, IA 51016	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	χ (E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	in the room. He off foot, stoked it and then kissed her foo no one said anythin big deal. She said that Staff I took her down to the area we pouring down rain. Until they got into the changed, he pulled (alcohol) out from that he started drint day. She said that "dirty" music. She state that he made and reported the lyrics darkness, she did pants. With his right her neck, pulled he into his lap. She sain her mouth, she of from his phone in him eant that he vide that after the incide room and did not to remembered that Stays after the incide room and the vide that after the incide room and did not to remembered that Stays after the incide room and did not to remembered that Stays after the incide about the event.  Resident #1's Clini reviewed on 11/14, following medication drowsiness:  a. Dilaudid (opioid (mg) every 4 hours b. Lorazepam (antievery 12 hours as	he put on her socks, Staff I was bered to put one on, held her said "you have beautiful feet," but. She felt surprised by this but any and he acted like it was no used a wheelchair on the night of the his car. He wheeled her with trees, in the dark and the laughed and joked with her the car. Once inside, his mood if a bottle of Crown Royal under his car seat and told her alking it at the beginning of the he then put on some loud, said that he shared with her recorded his own music. She has violent. Due to the not see his penis outside his at hand he grabbed the back of the hair, and shoved her head haid that while she had his penis could see a bright light coming his left hand. She knew that otaped her. Resident #1 said that, she went directly to her talk to anyone. She staff I did not work for several lent. Then they never talked call Physician's Orders (23 at 10:14 AM included the ons that could cause)	F	500				

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	mg twice a day.  A review of the weath rained with showers.  Timesheet records sl 10/12/23 from 6:02 P  Resident #1's text me sent Staff I a message then again at 10:58 P him to send the video and on 10/13/23 at 7 to her asking "how air respond to that mess PM and said that she 16th at 5:24 PM she money to him if he working resident #1's a with another \$21.00 states Resident #1's Cash A 10/22/23, of \$22.00 states account.  On 11/16/23 at 8:56 accepted money from buy her some pop arit was not right.  On 11/8/23 at 10:48 A (DA), said that on the she waited outside the shift, she sat on the put that time, Resident #1 her cigarettes. He working the some sent that time, Resident #1 her cigarettes. He working the some sent that time, Resident #1 her cigarettes. He working the some sent that time, Resident #1 her cigarettes. He working the some sent that time the sent that time, Resident #1 her cigarettes. He working the sent that the sent t	pain medication) sulfate 30  ther history indicated that it on 10/12/23 in the area.  Thow that Staff I worked on 10/14/23 PM.  The sesages revealed that she are at 9:57 PM on 10/12/23, PM in which she reminded by the then sent the video, 1:42 PM he sent a message are you?". She did not the age until 10/15/23 at 8:16 are was not feeling well. On the offered to Cash App some	F 6				

T '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		165323	B. WING _			C 11/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	forced her to performere drinking alcohanyone to know abothen stopped over a when Resident #1 to but her phone need show them. She detrembling when she said Resident #1 remight do if he knew.  On 11/8/23 at 10:32 evening of 10/23/23 outside with Staff A A looked at Resider her?" Resident #1 s A proceeded to tell video of himself mathey needed to report he next morning a went in the next morning a went in the next morning a went in the resident #1 shad Staff I morning. He showe his phone for \$10.0 from the building. Wallegations of sex, to confronted Resident #1. He actake her out to smoother to show the should be actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1. He actake her out to smoother and staff I denied a Resident #1.	to his car one night and m oral sex. She said that they ol and she did not want but it. Staff F, Nurse Aide (NA), and entered the conversation old them that she had a video, ed to charge, so she could not scribed Resident #1 as told them the story. Staff A ported being afraid of what he she told anyone.  AM, Staff F said that on the she approached them. Staff it #1 and asked "can I tell shook her head "yes" and Staff ther that Staff I sent her a sturbating. They agreed that ort that to the Administrator. round 10:00 AM they both	F 6				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE COMP	SURVEY LETED			
		165323	B. WING				20/2023
	ROVIDER OR SUPPLIER	CARE	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	signed by Resident # Administrator had cor accused her of provic cigarettes. Resident # by the allegations, an anything so vile. She the hand-written note forced sexual acts.  On 10/24/23, the Reg added the following to a. Staff caught Resid building smoking. b. Resident #1 had a involved manipulating stories that did not ha  According to a Social Evaluation dated 9/26 did not make accusal her as not worried, no did not have mood sy  The follow-up Behavi 10/10/23 at 1:58 PM conclusion.  On 11/13/23 at 8:47 A role as to oversee the facilities in the region in the building about o mainly spend her time leadership, resulting in	lated 10/24/23 at 8:52 AM, 1, indicated that the infronted Resident #1 and ding sexual favors for #1 reported being very upset id that she would never do denied the allegations and elacked any reference to  gional MDS Coordinator (RC) or Resident #1's Care Plan; ent #1 outside in front of the behavior problem that g staff, and making up appened.  Services Behavior History 6/23 at 9:28 AM, Resident #1 tory statements, described of anxious, not tearful, and wings.  oral History completed on resulted with the same  AM the RC described her e MDS coordination for the . She said that she would be with the MDS staff and in her not being very familiar the said that they talked about	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING	B. WING		C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZII 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Resident #1's Care explained it as a gro of focus, based on F snacks to her advan Resident #1 told a s tied her down and sl wrist from that, but sexamples of any ma facility. When asked Staff I, she said she that staff member, o maintained that in the she changed the carnot talk about the about the about the about the about the she changed that wher leadership meeting to 10/24/23, they discuallegations about Staff I, would see and nights. In the dadischarge, she starte evenings and interact ask to go outside even and sit on the bench go too far with her would there for long pe Staff I for more than	che made the addition to Plan on 10/24/23. She up effort to include that area Resident #1 sharing and using tage with staff. She said that tory about how the hospital ne received the wound on her he did not know about de-up stories while at the about allegations against did not know anything about a rallegations of abuse. She eir leadership meeting when the plan on 10/24/23, they did buse allegations  Staff D, Registered Nurse and RC came to the morning that she attended on ssed Resident #1's abuse	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 1/20/2023	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		1/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 10	F 60	00			
	she witnessed Staff #1 outside on the pa for over an hour.  On 11/8/23 at 11:55 only worked at the fa she would never go day she worked at th yelled at Resident #1 to pack up her room Resident #1 as cryin Resident #1 told her took a video of it. Wi #1 pack her things o	M, Staff L, CNA, said that I spending time with Resident tio. They would be out there  AM, Staff M, CNA, said she icility a couple of times and back. She said that the last refacility, the Administrator I, giving her only 30 minutes and leave. She described g and shaking. She said that that Staff I raped her and he hile Staff M helped Resident in 10/25/23, the Administrator ch other. Resident #1					
	(RN), said that she was the described Resider and the other resider items delivered to the would share her sna out on the patio. Sta and then spend time  On 11/8/23 at 3:30 F she did not see any Resident #1 and Sta saw the video of him that she worked with him as very invasive bubble." She said the Staff I forcing her he sex and that he reco	ff I. She did report that she masturbating. Staff Q said him before. She described and would get into "your at Resident #1 told her about ad in his lap to perform oral					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 1/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	100000		STREET ADDRESS, CITY, STATE, ZIP CO		1/20/2023	
				1116 EAST HIGHWAY 20			
CORRECT	IONVILLE SPECIALT	/ CARE		CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	him into her office. purchased cigarette that he did and sho said "the lady sent cigarettes." The Ad ever took Resident cigarettes and he to he chose to leave to because he would there anymore. He facility and finished denied having any Resident #1 and sa little bit on the patic messages and said anything wrong with purchase of cigarethe worked in different problem with buying said that he did not Resident #1. When had the wrong imported the worked in different problem with buying said that he did not Resident #1. When had the wrong imported the interview. He madd the interview. He madd the interview with the madd the sexual interactions Staff I then chuckled an intelligence officithings. He thought of the interaction be	O AM, the Administrator called She asked him if he es for a resident, he told her wed her the Cash App. He me money and I bought her ministrator asked him if he #1 in his car to go purchase old her that he did not. He said he facility on 10/24/23 not feel comfortable working said that he went to a sister up a shift that same day. He kind of relationship with hid that he would sit with her a b. He denied sending her any I that he did not feel he did in accepting her money for the tes. Staff I went on to say that ent states and did not have a go things for residents. Staff I spend much time with asked if he thought that she ression about their asked what the questions not understand the reason for anintained that the ot bring up or ask about any between him and Resident #1. d and said that he worked as er and learned to record that he may have a recording etween himself and the	F	600	()		
	magnetism, I can o stellar worker." He him to work other s mentioned three ot shifts after the 24th	aid "I am keeping my vercome obstacles I am a said that the company begged hifts since 10/24/23. He her facilities that he completed . He did not understand that if something wrong, why they					

165323	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1	C <b>1/20/2023</b>
		STREET ADDRESS CITY STATE ZIP CODE		I/EU/EUE
CARE		1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
ue to work for the company? pset and described the terous.  M, Staff C, CNA, said that at night and she knew when her pain pills. Resident #1 on the patio for hours, Staff she did out there for so long, e said that Staff I would long after his shift ended at s he slept in his red car hig lot at the facility. She flirty" with some staff  AM the Regional Director of r leadership team had a he call regarding the at #1 on 10/24/23. She said ersation was related to the r exchange from resident to on included very little sexual innuendos. She said er conveyed to them that Staff that simulated eeting did not include tions of forced sexual  PM the Regional Manager se team did not get all the ate information from the	F 600			
	e 12  ue to work for the company?  set and described the terous.  M, Staff C, CNA, said that at night and she knew when the pain pills. Resident #1  on the patio for hours, Staff she did out there for so long, the said that Staff I would tong after his shift ended at the she slept in his red car and lot at the facility. She lirty" with some staff  MM the Regional Director of a leadership team had a fine call regarding the the theorem was related to the exchange from resident to an included very little sexual innuendos. She said conveyed to them that Staff that simulated the the sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual innuendos of forced sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated the thing of forced sexual was related to the sexual was related to the sexual was related to the sexual innuendos. She said conveyed to them that Staff that simulated sexual was related to the sexual	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  F 12  Let to work for the company? Deset and described the terous.  M, Staff C, CNA, said that at night and she knew when the pain pills. Resident #1 In the patio for hours, Staff she did out there for so long, the said that Staff I would long after his shift ended at the she slept in his red car and lot at the facility. She lirty" with some staff  MM the Regional Director of a readership team had a she call regarding the the treatment of the exchange from resident to an included very little sexual innuendos. She said conveyed to them that Staff that simulated the test in formation from the site information from the site information from the	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  12 12 F 600  14 12 F 600  15 12 F 600  16 12 F 600  17 12 F 600  18 12 F 600  18 12 F 600  19 14 15 F 600  19 15 F 600  19 15 F 600  19 16 F 600  19 16 F 600  19 17 F 600  19 18 18 18 18 18 18 18 18 18 18 18 18 18	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  12  12  13  14  15  16  17  17  18  17  18  18  19  19  19  19  19  19  19  19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		165323	B. WING _			C 11/20/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	'	1112012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	reported that she tra mobile app to purcha received a verbal wa any reason from a re did not include any re allegation.	e 13 ion on 10/23/23 as a resident insferred money to him on a ase cigarettes for her. He rning not to take money for isident. The verbal warning eferences to a sexual abuse ual facility survey report I recorded a resident	F 6	00		
	without her consent file lacked a correctivindication that the fawith him.  Staff I's timesheet shwork with vulnerable facilities on 10/24/23 10/28/23 from 10:19 10/30/23 at 10:01 PM	or knowledge. His personal ve action form or any cility addressed that incident nowed that he continued to elderly population in their from 2:04 PM - 7:02 PM, PM - 6:14 AM, and on M - 6:00 AM.				
F 607 SS=G	dated November 202 had the right to be from isappropriation of rexploitation. This incostaff from taking pict degradation, including photographs or reconcept Develop/Implement and CFR(s): 483.12(b)(1 §483.12(b) The facility	Abuse/Neglect Policies )-(5)(ii)(iii)	F 6	07		
		it and prevent abuse, tion of residents and esident property,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING				20/2023
	ROVIDER OR SUPPLIER	ARE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		0,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	÷ 14	F	607			
	§483.12(b)(2) Establito investigate any suc	sh policies and procedures ch allegations, and					
	§483.12(b)(3) Include paragraph §483.95,	training as required at					
	§483.12(b)(4) Establic QAPI program require	sh coordination with the ed under §483.75.					
	§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.						
		ting a conspicuous notice of efined at section 1150B(d)					
	retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on interviews, review the facility failed	hibiting and preventing at section 1150B(d)(1) and is not met as evidenced record review and policy ed to prevent retribution to a					
	(Resident #1). Reside Certified Nurse Aide ( After the facility learne 10/24/23, they discha homeless shelter on approximately 30 min Staff P reported that t	utes to pack. In addition, he facility suspended her he Administrator regarding					
	suspended Staff Q fro	om work for not reporting after she learned about the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STAT 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 5		1112012020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIATI FICIENCY)	(X5) COMPLETION DATE
F 607	the facility already known facility asked her to some abuse to speed a could return to work treatment of Resider of the allegation of a become afraid and could yelling between her asked for the allegation of a become afraid and coupelling between her asked for the allegation of a become afraid and coupelling between her asked for the second for the second for the second for the second for transfers, personal hygiene. The frequently incontinent continent of bowel. To for disorder of the kid hypertension (high bound for the second for the sec	e she reported the allegation, new from other staff. The share information related to up their investigation so she sooner. Due to the facility's at #1 after the facility learned buse, caused Resident #1 to ry during an exchange of and the Administrator.  The property of the facility learned buse, caused Resident #1 to ry during an exchange of and the Administrator.  The property of the facility learned buse, caused Resident #1 to ry during an exchange of and the Administrator.  The property of the facility learned buse, caused Resident #1 as the facility of the facil	F	607		
		le her own hygiene, toilet				

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORI (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE A DEFICIENCY)		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE			
F 607	Interventions reflecte front wheel walker.  On 11/6/23 at 2:13 P when she reported homembers, somehow, around. Due to this sthe facility any more. Administrator came in yelling, and told her to	ependent in the facility. The d that Resident #1 used a  M, Resident #1 said that er abuse to a couple of staff they twisted the story he did not trust anyone at She said that the into her room one day,	Fé	607			
	sexual favors for cigal staff took her outside shared with a couple attacked her. She cowhen Staff I took her perform oral sex on high planning her discharge told her that she planso her son could com Women's and Childre but her son was took	rettes. Resident #1 said that to have cigarettes, and she of them. Staff I sexually uld not remember the date to his car and made her him. Resident #1 said when ge, the Social Worker (SW) and to help her find housing he and live with her. The en's Shelter was an option old to go there. She said she sked her out because of the					
	that on 10/24/23, a conternation to Resident #1, and his phone. The Admin Staff I come into her showed her the Cash for \$10.00, and she shoulding. When asked sex, the Administrator Resident #1 about procigarettes, but she decome a situation of the state of the stat	M, the Administrator said ouple of staff members told with Staff I buying cigarettes that he used a Cash App on nistrator said that she had office that morning. He a App receipt on his phone suspended him from the d about the allegations of it said that she confronted oviding sexual favors for enied it. She said that Staff I stivity with Resident #1. He					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING				C <b>20/2023</b>	
	ROVIDER OR SUPPLIER	CARE	<b>.</b>	1	TREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	smoke but denied any Administrator said that stating that it was false. A hand-written note of signed by Resident # Administrator confrom accused her of provincing accused he	e would take her out to ything sexual. The at Resident #1 wrote a letter se and denied everything.  Intel 10/24/23 at 8:52 AM, 1, indicated that the sted Resident #1 and sing sexual favors for #1 reported being very upset do that she would never do denied the allegations and lacked any reference to PM, the Police Officer who #1 on 11/1/23 described her ery embarrassed when she abuse. He said that when what happened, she ficulty describing the sexual leing heavily medicated and could not give consent. at Staff I sent her a sexually elf.  Idated 10/24/23 at 12:00 AM and Registered Nurse 10/26/23 at 8:08 PM	F	607				

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING				20/2023
	ROVIDER OR SUPPLIER	CARE	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	recommended to folks six months and she was of medications.  On 10/24/23, the Regarded the following to a Staff caught Reside building smoking.  b. Resident #1 had a involved manipulating stories that did not has a considered for the following to a Social Evaluation dated 9/26 did not make accusate her as not worried, not did not have mood sworth for the follow-up Behavit 10/10/23 at 1:58 PM conclusion  On 11/13/23 at 8:47 A role as to oversee the facilities in the region in the building about mainly spend her time leadership, resulting with the residents. She the residents in morn acknowledged that she resident #1's Care Pexplained it as a group of focus, based on Resident #1 told a statied her down and she time for the facilities in the residents as a group of focus, based on Resident #1 told a statied her down and she time for the facilities in the resident #1 told a statied her down and she time for the facilities in the resident #1 told a statied her down and she time for the facilities in the resident #1 told a statied her down and she time for the facilities in the resident #1 told a statied her down and she time for the facilities in the resident #1 told a statied her down and she time for the facilities in the resident #1 told a statied her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the facilities in the resident #1 told a statiet her down and she time for the	Resident #1. The NP ow-up for medication refills in would provide a 7-day supply  gional MDS Coordinator (RC) o Resident #1's Care Plan: ent #1 outside in front of the behavior problem that g staff, and making up appened.  Services Behavior History 6/23 at 9:28 AM, Resident #1 tory statements, described ot anxious, not tearful, and wings.  oral History completed on resulted with the same  AM the RC described her e MDS coordination for the . She said that she would be with the MDS staff and in her not being very familiar he said that they talked about ing meetings. She he made the addition to	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		165323	B. WING _			C <b>11/20/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	facility. When asked Staff I, she said she that staff member, or maintained that in the she changed the canot talk about the all on 11/13/23 at 9:00 (RN), said that whe leadership meeting 10/24/23, they discuallegations about Staff, said that on the loaded up the remains belongings in her put them to the shelter. came with a very small her items in that Resident #1 pack her angry, crying, and skicked her out. She someone above the was happening. She Resident #1 items at the son. When aske shelter the level of the shelter, she swe continued by expensions "related" behaviors" related.	ade-up stories while at the dabout allegations against add not know anything about or allegations of abuse. She heir leadership meeting when are plan on 10/24/23, they did buse allegations.  9, Staff D, Registered Nurse in RC came to the morning that she attended on ussed Resident #1's abuse	F 6	07		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		165323	B. WING			C 1/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	, <u>.</u>	172072020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	therapy told her that walker. The Region arranged to get her she wanted to get or Resident #1's admis 911 that night, but shappened after that anything about Staff maintained that she permission to make the shelter.  On 11/9/23 at 10:45 the SW said that the shelter.  On 11/9/23 at 10:45 the SW said that the the homeless shelter Afterwards, she ma arrangements. She very upset shelter reabout Resident #1 a heart attack." They they could see whather that they could her behaviors and regoals and she want questioned about if medical information homeless person of a shelter with their ras that is what they  On 11/13/23 at 3:00 a discharge checklist they can go down the hitting on the planning 24-hour notice chall get the transportation conversation with Region 1.5 and 1	all needs, she responded that the Resident #1 could use a all Director of Nursing a walker to take with her but but. She said that after assion to the shelter, she called the did not know what a she denied knowing a to cigarettes. She as had Resident #1's the arrangements to go to a she was about admitting her. The de the transportation as and that she got a call from a depresentative the next day and said that she "faked a sent her to the hospital, and the she was like. The SW told the totake her back because of the sent Resident #1's with her, she replied no, as a fifthe street did not come into medical diagnosis information. do.  In PM the SW said that they put as ton the wall in her office so the list and make sure they are ng points. She said the lenged her with the need to	F 60	07			

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		165323	B. WING _			C 11/20/2023
	ROVIDER OR SUPPLIER	/ CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From pa	ge 21 arge sooner as they had a	F 6	07		
	4-hour notice. Resi	dent #1 reported she was fine tter because then her sister				
	AM, revealed that the time without Reside	recording from the pany, dated 10/25/23 at 7:28 the SW called for a ride at that ent #1 in the room with her. the arrangements, she				
	chose the 4-hour pi works for me." They	ck-up time and said "that y finalized the arrangements any found a driver, they would				
	Nurse (RN), said ea went around to say and staff. Later that that she only had a together and packe #1 expressed that s her out. Staff N said had a plan for disch abruptly. Staff N rep that Resident #1 we without nursing sen	o AM Staff N, Registered arly that morning, Resident #1 good bye to other residents to morning when she found out half hour to get everything and she started to cry. Resident she felt like the facility kicked to that she understood that they harge but it came very ported that she had concernsent to a homeless shelter vices especially when she as the provider just changed				
	called back and sai company just dropp shelter with no pape said they did not typ hospital or nursing know what level of they can determine	AM Shelter Staff 1 (SS1) d that the transportation ped Resident #1 off at the erwork and no phone call. She pically accept residents from a home that way. They need to care the resident required so if they are appropriate or if em. On 10/25/23 around 1:00				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·			(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C <b>1/20/2023</b>	
	ROVIDER OR SUPPLIER	TY CARE		STREET ADDRESS, CITY, STATE, ZIP C 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	•	1/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Initially, the cab driver did not they would not act the facility, who to homeless shelter. Then she had to led daughter worked to called 911 due to and unstable arous 6:15 AM on 10/26 soiled back at the clean up and she Around 11:00 AM friend came and pnot know what half to get too involved situations once the facility made hoff Resident #1 with on her level of need children here" and did call and talk to not make the arraithey would not tak she made allegation.  On 11/13/23 at 7:2 fact that no one tabefore Resident # said that when the hospital, they put the said that when the hospital they are said that when the hospital that when the hospital they are said that when the hospital they are said that when the hospital they are said the said that when the hospital they are said the said they are said th	tion company dropped her off. river dropped her off at a safe r domestic violence victims. know what to do with her when cept her there, so, they called ld them to take her to the SS1 did the intake herself and ave early that day. Her there in the afternoon and she Resident #1 shaking, falling, and 4:00 PM in the afternoon. At //23 the hospital returned her shelter. They got her a room to talked to a friend on the phone. on the 10/26/23, Resident #1's icked her up. She said she did opened from there. They try not in the resident's lives or ey leave the shelter. She said her very upset for just dropping thout first having a consultation ed. She explained that "we have it do not have nursing staff. She in the SW who said that she did negements and indicated that the Resident #1 back because	F	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165323	B. WING _			1	C <b>20/2023</b>
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP O 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 607	Continued From page		F 6	607			
	where they sent her.	them that she did not know She said that they will never facility ever again or with					
	day she talked to any day that Resident #1 They write down their computer and they had contacted them regard there. Resident #1 was about the driver becawith the facility. Origin place first and then dher things. Then the Resident #1 got there Resident #1 could be shortness of breath. I holding up the driver, when they started un things and said that the	PM SS2 said that the first one at the facility was the showed up at their door. In notes or document on the ave no notes that someone ding Resident #1 coming as at the door, concerned use he was on the phone hally, he went to the wrong id not know what to do with SW called back just after a and SS2 told her that rely walk, shook, and had Resident #1 worried about SS2 recalled her surprise loading all of Resident #1's hey could only allow 2 bags.					
	everything. SS2 talker telling her about Residid not know if they of The SW told her that they could not take her that they did not know responded that she wof that. SS2 started the non-emergent care to seemed so unstable, medications, they are on their own. SS2 saithere before, it was a did not have a record	nt #1 he had a TV and d to the SW on the phone dent #1 not stable and she ould take care of her there. because of her behaviors er back. She told the SW v about her coming, the SW v/as sure someone took care ne intake and later called o pick her up because she She did come with some er responsible for taking them id if Resident #1 stayed long time ago because she of her being there.  AM Staff P. Former Office					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	_	e 24 he no longer worked at the he administration was	F	607			
	looking for some rea she questioned them the proper authorities about the allegations 10/24/23 and sent a at 5:30 PM, expressi event. She then she corporate that Reside allegations so they dereport it. She said that on the 25th, her office because they were look	son to terminate her because on reporting the events to s. Staff P said that she heard of abuse later in the day on text to the Regional Manager ng that they should report the got a call back from					
	that the facility susper pending investigation allegations of abuse learned about the inci- knew about the incid- said that the facility to could speed up if she	PM Staff Q, CNA, explained ended her from working in, because she did not report within 2 hours. When she cident, the facility already ent from someone else. She old her that their investigation is could provide a copy of any les that exchanged between if I.					
	Nursing (RDON) said Resident #1's dischal gave her a list of her Plan, and a summary while she went throu Resident #1, the Adr the room. Resident # not say why the Adm that Resident #1 did	AM the Regional Director of a that she assisted with rge. She maintained that she medication, diagnoses, Care of her stay. She said that gh the discharge with ministrator poked her head in the called her a "bitch" but did inistrator upset her. She said not share any concerns with red her other avenues to file					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609 SS=J	10/9/23. Resident #1 the transfer. She said up, Resident #1 said could only have 3 bag the SW disagreed wit would take all her thir  The Dependent Adult November 2019, desi keeping resident free screening and training residents and preven investigation and time neglect, mistreatment proper, without the fe intimidation. Reporting of Alleged CFR(s): 483.12(b)(5)	s not interested. She planned the discharge since knew about it and agreed to that as they packed things that she thought that she gs of items at the shelter, but h her, and said that they ngs.  Abuse Protocols dated cribed the procedure for from abuse include g employees, protection of tion, identification, ely reporting of abuse, t, and misappropriation of ar of recrimination or  Violations (i)(A)(B)(c)(1)(4)		607			
	neglect, exploitation, must:  §483.12(c)(1) Ensure involving abuse, negl mistreatment, includir source and misappro are reported immedia hours after the allegathat cause the allegates serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to a serious to a serious bodily injury).	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, ttely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP C 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		1112012020
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	Continued From page	e 26	F	609		
		-term care facilities) in e law through established				
	designated represent accordance with Stat Survey Agency, withis incident, and if the all appropriate corrective This REQUIREMENT by:  Based on clinical recreview, staff, and restailed to report allegation of 3 residents recreased the staff member sexuall transferring money for facility did not report.	administrator or his or her tative and to other officials in the law, including to the State on 5 working days of the leged violation is verified to action must be taken.  To is not met as evidenced expression of abuse within 2 hours eviewed (Resident #1).  It to staff on 10/23/23 that a y abused her, in addition to oom her account to staff. The				
	Findings include:					
	Immediate Jeopardy 10/23/23 on 11/9/23 a removed the IJ and do on 11/13/23 with the a. The facility provide i. Dependent adulincluding consensual	at 4:00 PM. The facility decreased the scope to a "D" following actions: ed the following education: t abuse and sexual abuse vs. non-consensual ed to immediately report the				
	ii. Spotting Signs of caretaker boundaries	of Elder Abuse to include s on 11/10/23.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, 2 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE ITO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 609	purchasing personal 11/10/23.  iv. Discharge/tran resident-initiated disconneeds of the resident v. Supervision of b. The facility intervie and oriented resident the facility audited the non-verbal signs of a c. The facility update Checklist to include A dependent adult abuing professional boundar Resident #1's Minimulassessment dated 9/Interview for Mental sindicating intact cognicating intact cognication into	spectations regarding items for residents on sfer policy, highlighted charge including meeting the welfare on 11/10/23. Soutdoor visits on 11/13/23. Sewed residents on all the alert its on 11/11/23. In addition, we remaining residents for any buse. In the Agency Orientation whose Protocol to highlight see reporting policy and ries.  Sum Data Set (MDS) 24/23 identified a Brief Status (BIMS) score of 14, sition. The assessment int #1 did not have behaviors. Ilmited assistance from one dressing, toilet use, and the MDS listed Resident #1 as to furine and always the MDS included diagnoses	F	609			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165323	B. WING	·····		C 11/20/2023
	ROVIDER OR SUPPLIER	CARE	STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	independently providuse, and transfers. c. Resident #1 is indefiniterventions reflecte front wheel walker.  On 11/8/23 at 10:48 / (DA), said that on the she waited outside of her shift and sat with Resident #1 told her Aide (CNA), bought her phone and transf Cash App. After this, he took her to his car perform oral sex on hithey were drinking all anyone to know about then stopped over an when Resident #1 tol from Staff I, but she riso she could not shor Resident #1 trembled story and expressed he knew she told any  On 11/8/23 at 10:32 / evening of 10/23, Re Staff A and when she at her and asked "cai shook her head "yes' tell her that Staff I sei masturbating. They are port this to the Admit and the staff I sei masturbating. They are port this to the Admit and the said the staff I sei masturbating. They are port this to the Admit and the said the	wing (ADLs). The d that Resident #1 could e her own hygiene, toilet ependent in the facility. The d that Resident #1 used a  AM, Staff A, Dietary Aide e evening of 10/23/23 while f the facility for a ride after Resident #1 on the patio. that Staff I, Certified Nurse her cigarettes, then he took erred money into his own Resident #1 told Staff A that e one night and forced her to him. Resident #1 said that cohol and she did not want at it. Staff F, Nurse Aide (NA), and entered the conversation d them that she had a video heeded to charge her phone, w them. She said that d when she told them the fear of what he might do if	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _		_	C I1/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STA 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA	ATE, ZIP CODE	11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 609	that on 10/24/23, a her about a situation for Resident #1, and his phone. The Adm Staff I come into her showed her the Cas for \$10.00, and she building. When aske sex, the Administrat Resident #1 about prograttes, but she denied any sexual a acknowledged that I smoke but denied a Administrator said the stating that it was far A hand-written note signed by Resident Administrator confrouction accused her of proving arettes. Resident by the allegations, a anything so vile. She the hand-written not forced sexual acts.  The complaint unit forced sexual acts.  The Sheriff's Office at 6:22 PM, reflected Representative internal legations of sexual her time as a reside	PM, the Administrator said couple of staff members told in with Staff I buying cigarettes if that he used a Cash App on inistrator said that she had roffice that morning. He is hap receipt on his phone suspended him from the ed about the allegations of or said that she confronted providing sexual favors for lenied it. She said that Staff I citivity with Resident #1. He ne would take her out to	F	509			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165323	B. WING		C 11/20/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	,20,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 609	kiss her inappropriat and on her feet. She her discharge, she whave a cigarette and asked if she would li car and she agreed. and while in the vehi oral sex on him. She small red car parked highway.  On 11/14/23 at 2:15 interviewed Residen as forthcoming but vicame in to the report she tried to describe stumbled and had di act. She mentioned while at the facility a She told the officer the explicit video of hims.  On 11/13/23 at 10:30 Manager, said that stacility. She felt that looking for some reast she questioned them the proper authoritie about the allegations 10/24/23 and sent a at 5:30 PM, expressivent. She then she corporate that Resid allegations so they dreport it. She said the on the 25th, her officibecause they were likely and sent a side of the corporate that Resid allegations so they dreport it. She said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said the on the 25th, her officibecause they were likely as the said th	her, Staff I would touch and ely on the back of the neck said that 2-3 weeks prior to vent outside the facility to it had been raining. Staff I ke to have her cigarette in his He wheeled her to the car cicle, he forced her to perform the described the vehicle as a by the row of trees near the  PM, the Police Officer who that the the said that when what happened, she efficulty describing the sexual being heavily medicated and could not give consent. The hat Staff I sent her a sexually self.  DAM Staff P, Former Office the no longer worked at the the administration was son to terminate her because in on reporting the events to so Staff P said that she heard so of abuse later in the day on text to the Regional Manager ing that they should report the got a call back from	F 60	9	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· '	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	<b>.</b>	11/29/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	Nursing said that the "rapid response" ph concern with Reside that most of the concornern about mone staff. The conversal discussion regarding that the Administrate I only made a motio masturbation. The ranything about allegactivity.  On 11/14/23 at 2:50 said the rapid responsion or accurate Administrator to det said that had they k would have made designed will design management to investigate assess the resident to primary care provisitness statements known witnesses. T	AM the Regional Director of eir leadership team had a one call regarding the ent #1 on 10/24/23. She said versation was related to the ey exchange from resident to ion included very little g sexual innuendos. She said or conveyed to them that Staff in that simulated neeting did not include jations of forced sexual  PM the Regional Manager inse team did not get all the rate information from the ermine the next steps. She nown all the details, they ifferent decisions.  Administrator or his/her instead a member of estigate the alleged incident to esessment of resident injury, for injury, provide notification inder, and attempt to obtain (oral and/or written) from all the facility will establish and	F6	09		
F 610 SS=J	individuals to report fear of recrimination	nent that encourages allegations of abuse without (blame) or intimidation. Correct Alleged Violation	F 6	10		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING			1	C / <b>20/2023</b>
	ROVIDER OR SUPPLIER	CARE	•	1116	EET ADDRESS, CITY, STATE, ZIP CODE 6 EAST HIGHWAY 20 RRECTIONVILLE, IA 51016	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	neglect, exploitation, must:  §483.12(c)(2) Have eviolations are thorouge §483.12(c)(3) Prevention	se to allegations of abuse, or mistreatment, the facility evidence that all alleged ghly investigated.  It further potential abuse, or mistreatment while the gress.	F	510			
	investigations to the designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by:  Based on interviews enforcement, record facility failed to adeque of abuse for 1 of 3 re #1). After Resident # sexual and financial and only addressed the eminimized and failed allegations of sexual Findings include:  The State Agency inforcements accordingly addressed the eminimized and failed allegations of sexual Findings include:	administrator or his or her tative and to other officials in le law, including to the State in 5 working days of the leged violation is verified e action must be taken.  This not met as evidenced with residents, staff and law review and policy review the lately investigate allegations sidents reviewed (Resident 1 reported allegations of labuse, the administration xchange of money but to fully investigate the abuse.					
		at 4:00 PM. The facility lecreased the scope to a "D"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING				20/2023
	ROVIDER OR SUPPLIER	ARE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		0,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	i. Dependent adult including consensual education and the net allegation on 11/10/23 ii. Spotting Signs of caretaker boundaries iii. The facility's expurchasing personal in 11/10/23. iv. Discharge/transresident-initiated disconeeds of the resident v. Supervision of ob. The facility intervie and oriented resident the facility audited the non-verbal signs of all c. The facility updated Checklist to include A dependent adult abus professional boundaring Resident #1's Minimulassessment dated 9/2 Interview for Mental Sindicating intact cognizeflected that Resider Resident #1 required person for transfers, opersonal hygiene. The frequently incontinent continent of bowel. The of disorder of the kidning hygiene (high ble	d the following education: a abuse and sexual abuse vs. non-consensual ed to immediately report the 3. of Elder Abuse to include on 11/10/23. pectations regarding tems for residents on sfer policy, highlighted harge including meeting the welfare on 11/10/23. outdoor visits on 11/13/23. wed residents on all the alert s on 11/11/23. In addition, e remaining residents for any ouse. d the Agency Orientation buse Protocol to highlight se reporting policy and ies.  Im Data Set (MDS) 24/23 identified a Brief Status (BIMS) score of 14, ition. The assessment of #1 did not have behaviors. limited assistance from one dressing, toilet use, and e MDS listed Resident #1 as a of urine and always ne MDS included diagnoses	F	610			
	Stress Disorder (PTS	D), and malignant neoplasm ancer). The assessment					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP COL 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	pain.  The Care Plan includated 10/3/23: a. Resident #1 plant Goal listed that Resto the community. b. Activities of daily Interventions directer independently proviouse, and transfers. c. Resident #1 is included interventions reflect front wheel walker.  On 11/8/23 at 10:48 (DA), said that on the she waited outside the shift and sat with Resident #1 told her Aide (CNA), bought her phone and transcash App. After this he took her to his caperform oral sex on they were drinking a anyone to know abothen stopped over a when Resident #1 to from Staff I, but she	ent #1 almost always had  ded the following Focuses  ned to rehab to home. The ident #1 would transition back	F	510		
	story and expressed he knew she told an On 11/8/23 at 10:32 evening of 10/23, Ro	ed when she told them the I fear of what he might do if I yone.  AM, Staff F said that on the esident #1 sat outside with e approached, Staff A looked				

AND DUAN OF CORRECTION		· /	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	ı	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 610	at her and asked "ca shook her head "yes tell her that Staff I se masturbating. They a report this to the Adnat around 10:00 AM the Administrator.  On 11/6/23 at 2:13 P when she reported he members, somehow around. Due to this sthe facility any more. Administrator came if yelling, and told her because the staff repsexual favors for cigastaff took her outside shared with a couple attacked her. She cowhen Staff I took her perform oral sex on I her nice and spent ti she may have gave when she sent him to video of him pleasurion. On 11/8/23 at 2:18 P that on 10/24/23, a cher about a situation for Resident #1, and his phone. The Administrator showed her the Casl for \$10.00, and she shoulding. When aske sex, the Administrator Resident #1 about processes the staff of the Casl for \$10.00, and she shoulding. When aske sex, the Administrator Resident #1 about processes the staff of the Casl for \$10.00, and she shoulding. When aske sex, the Administrator Resident #1 about processes the staff of the Casl for \$10.00, and she shoulding. When aske sex, the Administrator Resident #1 about processes the staff of the Casl for \$10.00, and she shoulding. When aske sex, the Administrator Resident #1 about processes the staff of the Casl for \$10.00 and she should be s	n I tell her?" Resident #1 " and Staff A proceeded to nt her a video of himself agreed that they needed to ninistrator. The next morning they both went in to talk to  M, Resident #1 said that er abuse to a couple of staff they twisted the story he did not trust anyone at She said that the nto her room one day, that she had to leave forted that she provided arettes. Resident #1 said that to have cigarettes, and she of them. Staff I sexually uld not remember the date to his car and made her nim. She said that he treated me with her. She thought that nim the wrong impression texts. He then sent her a	F6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		11	TREET ADDRESS, CITY, STATE, ZIP CODE  16 EAST HIGHWAY 20  ORRECTIONVILLE, IA 51016	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC REFIX (EACH CORRECTIVE ACTION SHOULE TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 610	denied any sexual ac acknowledged that h smoke but denied an Administrator said the stating that it was fals.  A hand-written note of signed by Resident # Administrator confrom accused her of provide cigarettes. Resident by the allegations, an anything so vile. She the hand-written note forced sexual acts.  According to an untit investigation, two states Administrator that Reabout Staff I. She income were related to the pwhen Resident #1 we cigarettes, he made a	stivity with Resident #1. He e would take her out to ything sexual. The at Resident #1 wrote a letter se and denied everything.  Idated 10/24/23 at 8:52 AM, e1, indicated that the nted Resident #1 and ding sexual favors for #1 reported being very upset and that she would never do denied the allegations and e lacked any reference to led and undated facility off members reported to the esident #1 voiced concerns licated that the concerns urchase of cigarettes and ent to Staff I's car to get a gesture of oral sex while	F	310	DEFICIENCY)		
	Resident #1 denied to investigation indicated history of making falsevents to gain attentification separated Staff I from to purchasing cigared investigation statement the staff member who history of making allest that many staff and rehistory of making false Americans. The state contacted law enforces	d that Resident #1 had a se stories and exaggerating on. The Administrator in the facility and he admitted stes for Resident #1. The ent included comments that to reported the abuse, had a segations against Staff I, and esidents at the facility had a see allegations against African ement indicated the facility					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	<u>'</u>	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 610	interviews, and a resident with the chose to leave the chose the cho	the investigation lacked staff ident assessment.  AM a representative from the prough the files to see if they be facility on 10/24 or 10/25 be with Resident #1 as the predefit that they did not have collity regarding abuse  M, Staff I said that on alle had him working a 6a-6p AM, the Administrator called the asked him if he asked him if he asked him if he asked him if he are money and I bought her predefit that the did not. He said the facility on 10/24/23 be feel comfortable working and that he went to a sister up a shift that same day. He and of relationship with that he would sit with her a seed that he did not feel he did accepting her money for the test states and did not have a things for residents. Staff I pend much time with asked if he thought that she	F 61	0			
	· ·	sked what the questions not understand the reason for intained that the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		165323	B. WING			1	C <b>20/2023</b>
	ROVIDER OR SUPPLIER	CARE		111	REET ADDRESS, CITY, STATE, ZIP CODE 6 EAST HIGHWAY 20 DRRECTIONVILLE, IA 51016	1 11/	20/2023
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 610	Administrator did not sexual interactions be Staff I then chuckled an intelligence officer things. He thought the of the interaction betwork the interaction betwork administrator. He sai magnetism, I can overstellar worker." He sai mentioned three othershifts after the 24th. It they thought he did so allowed him to contine the reported feeling unallegations as preposed on 11/14/23 at 9:00 A Nursing said that their "rapid response" pho concern with Resider that most of the convector of the conve	bring up or ask about any etween him and Resident #1. and said that he worked as and learned to record at he may have a recording ween himself and the d "I am keeping my ercome obstacles I am a sid that the company begged fts since 10/24/23. He er facilities that he completed he did not understand that if comething wrong, why they ue to work for the company? pset and described the sterous.  AM the Regional Director of r leadership team had a ne call regarding the at #1 on 10/24/23. She said ersation was related to the rescal innuendos. She said conveyed to them that Staff that simulated enting did not include ations of forced sexual  PM the Regional Manager se team did not get all the ate information from the rmine the next steps. She own all the details, they	F	310			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING			1	C <b>20/2023</b>
	ROVIDER OR SUPPLIER	CARE		111	REET ADDRESS, CITY, STATE, ZIP CODE 16 EAST HIGHWAY 20 DRRECTIONVILLE, IA 51016	1 11/	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 610	2019 instructed that a allegation of resident immediately impleme further potential abus occurring while the faprocess. If this involvian employee, the fact separating the emploid all residents through combination of the form suspending the employee by moving the facility where their residents of the facility where their residents of the facility abuse need reported or his/her designee with management to invest include: review of assassess the residents of the facility with the primary care provious witness statements (or known witnesses. The enforce an environmental individuals to report a fear of recrimination (section titled Initial/Impracility Investigation receiving a report of a abuse, the facility shameasures to prevent residents from occurrinvestigation is in proallegation of abuse by will accomplish this by	apon receiving a report of an abuse, the facility shall nt measures to prevent e of residents from cility investigation is in es an allegation of abuse by ility will accomplish this by yee accused of abuse from the following or a llowing, if practicable: (1) byee; (2) segregating the the employee to an area of e will be no contact with any year allegations of resident immediately. Administrator will designate a member of estigate the alleged incident to be sessment of resident injury, for injury, provide notification der, and attempt to obtain oral and/or written) from all e facility will establish and ent that encourages allegations of abuse without blame) or intimidation. The inmediate Protection during instructed that Upon an allegation of resident all immediately implement further potential abuse of	F	510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 1/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		1723/2320	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULE TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622 SS=J	practicable: (1) suspessegregating the employee to an area will be no contact with Following completion the facility concludes resident abuse are unbe allowed to return the resident contact, but a separation and have resident alleged to have segregating the accust the facility where no obstween the accused alleged to have been maintain the separatic concludes its investigated for the segretary of the segretary	ation of the following, if anding the employee; (2) oyee by moving the of the facility where there of any residents of the facility. Of the facility investigation, if that the allegations of an any fersidents involving the employee must maintain the no contact with the enve been abused, by seed employee to an area of contact will be made employee and the resident abused. The facility must on until the Department ation and issues the written ation. Note: if the Department als, and Licensing (DIAL) is abuse (even though the intiate the abuse), there is ite the facility with for allowing an abuser to residents while the ed.  ge Requirements (i)(ii)(2)(i)-(iii)  and discharge-requirements-remit each resident to and not transfer or at from the facility unless-scharge is necessary for the dithe resident's needs	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 1/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	sufficiently so the res services provided by (C) The safety of indiendangered due to the status of the resident (D) The health of indiotherwise be endang (E) The resident has appropriate notice, to under Medicare or Sident who become admission to a facility resident only allowab or (F) The facility cease (ii) The facility may no resident while the apply \$431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility medically transfer when the facility transfer in paragraphs (c)(1)(i) section, the facility medically medical	is health has improved ident no longer needs the the facility; viduals in the facility is le clinical or behavioral straight in the facility would be red; failed, after reasonable and pay for (or to have paid bedicaid) a stay at the facility. If the resident does not paperwork for third party third party, including the facility may charge a seligible for Medicaid after of the facility may charge a sele charges under Medicaid; the facility may charge the poet is pending, pursuant to poter, when a resident sight to appeal a transfer or an the facility pursuant to \$ chapter, unless the failure to would endanger the health ent or other individuals in the flust document the danger for discharge would pose.	F 6	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			71. BOILE			، ا	С	
		165323	B. WING			1	20/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	20/2023	
					116 EAST HIGHWAY 20			
CORRECT	TIONVILLE SPECIALTY	CARE			ORRECTIONVILLE, IA 51016			
							I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 622	communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pa section, the specific be met, facility attern needs, and the servifacility to meet the n (ii) The documentatic (2)(i) of this section in (A) The resident's phidischarge is necessary (A) or (B) of this section in (B) A physician when necessary under part this section. (iii) Information provimust include a minim (A) Contact information (C) Advance Direction (C) Advance Direction (D) All special instruongoing care, as appin (E) Comprehensive (F) All other necessary of the resident's phidischarge is necessary under part this section.	appropriate information is a receiving health care r.  the resident's medical record a transfer per paragraph (c)(1)  ragraph (c)(1)(i)(A) of this resident need(s) that cannot upts to meet the resident ce available at the receiving eed(s).  on required by paragraph (c) must be made by- nysician when transfer or ary under paragraph (c) (1) tion; and an transfer or discharge is ragraph (c)(1)(i)(C) or (D) of a tided to the receiving provider num of the following: ion of the practitioner are of the resident.  entative information including are information ctions or precautions for propriate.	F	622	DEFICIENCY)			
	any other documents a safe and effective This REQUIREMEN by: Based on clinical re	ation, as applicable, to ensure						

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING				20/2023	
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE  116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	1 117	20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 622	adequately planned to reviewed (Resident #Resident #1 abruptly a homeless shelter that transfer. The homeles nurses on staff to me they did not have any homeless shelter transpital as she could homeless shelter. Aft shelter, Resident #1 If Findings include:  The State Agency informediate Jeopardy 10/23/23 on 11/9/23 aremoved the IJ and don 11/13/23 with the finding consensual education and the neallegation on 11/10/2 ii. Spotting Signs of caretaker boundaries iii. The facility's expurchasing personal 11/10/23.  iv. Discharge/transpersident-initiated disconneeds of the resident v. Supervision of control of the control of the supervision of control of the cont	ent's needs related to ransfers for 1 of 3 residents 1). The facility discharged after allegations of abuse to nat did not know of her as shelter did not have et her medical needs and a staff overnight. The asferred Resident #1 to the not safely remain in the er arriving to the homeless began to stumble and fall.  Formed the facility of the (IJ) that began as of at 4:00 PM. The facility ecreased the scope to a "D" following actions:  If the following education: the abuse and sexual abuse vs. non-consensual ed to immediately report the 3.  In felder Abuse to include on 11/10/23. Electations regarding items for residents on sefer policy, highlighted the harge including meeting the welfare on 11/10/23. Eventations on all the alert is on 11/11/23. In addition, the remaining residents for any	F	622				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165323	B. WING _				C 20/2023	
	ROVIDER OR SUPPLIER	CARE		1116 EAST HIG	ESS, CITY, STATE, ZIP CODE GHWAY 20 NVILLE, IA 51016	<u>,</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(E/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	Continued From page	e 44	F	522				
	Checklist to include A dependent adult abus professional boundar							
	Interview for Mental S indicating intact cogn reflected that Reside	24/23 identified a Brief Status (BIMS) score of 14, ition. The assessment nt #1 did not have behaviors.						
	person for transfers, personal hygiene. Th frequently incontinen	limited assistance from one dressing, toilet use, and e MDS listed Resident #1 as t of urine and always he MDS included diagnoses						
	of disorder of the kidi hypertension (high bl mellitus, anxiety, dep Stress Disorder (PTS of upper lobe (lung ca							
	dated 10/3/23: a. Resident #1 plann. Goal listed that Resident to the community. b. Activities of daily lister to the interventions directed independently providuse, and transfers. c. Resident #1 is independent in the independent in the independent independent in the independent independent in the independent independent independent in the independent	ed the following Focuses ed to rehab to home. The dent #1 would transition back ving (ADLs). The d that Resident #1 could e her own hygiene, toilet ependent in the facility. The d that Resident #1 used a						
	when she reported he	M, Resident #1 said that er abuse to a couple of staff they twisted the story						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		165323	B. WING		C 11/20/2023		
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		720/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	the facility any more. Administrator came ir yelling, and told her the because the staff represexual favors for cigal staff took her outside shared with a couple attacked her. She could have a couple attacked her. She could her that she plans to her son could compose offerred a homeless of could not go there dure felt like the facility kic lies told about her.  On 10/24/23, the Regarded the following to a. Staff caught Reside building smoking.  b. Resident #1 had a involved manipulating stories that did not have accusate her as not worried, not did not have mood sworth follow-up Behavit 10/10/23 at 1:58 PM is conclusion.	she said that the sto her room one day, shat she had to leave orted that she provided rettes. Resident #1 said that to have cigarettes, and she of them. Staff I sexually suld not remember the date to his car and made her im. Resident #1 said when se, the Social Worker (SW) shelter as option but her son the to his age. She said she sked her out because of the staff, and making up spened.  Services Behavior History 5/23 at 9:28 AM, Resident #1 ory statements, described to tanxious, not tearful, and	F 62				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		165323	<b>165323</b> B. WING		C 11/20/2023		
	ROVIDER OR SUPPLIER	CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016			20,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 622	in the building about mainly spend her tim leadership, resulting with the residents. St the residents in morn acknowledged that st Resident #1's Care Fexplained it as a groun of focus, based on Resident #1 told a st tied her down and sh wrist from that, but st examples of any made facility. When asked Staff I, she said she of that staff member, or maintained that in the she changed the care not talk about the about the about the about the about the about the staff member, or maintained that in the she changed the care not talk about the abo	She said that she would be once a week but she would e with the MDS staff and in her not being very familiar ne said that they talked about ing meetings. She he made the addition to plan on 10/24/23. She are esident #1 sharing and using age with staff. She said that be been about how the hospital ereceived the wound on her he did not know about allegations against did not know anything about allegations of abuse. She her leadership meeting when explan on 10/24/23, they did use allegations.  Staff D, Registered Nurse RC came to the morning hat she attended on seed Resident #1's abuse ff I.	F 6	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		165323	B. WING _			C 11/20/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		1/20/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 622	therapy told her that walker. The Regiona arranged to get her a she wanted to get ou Resident #1's admiss 911 that night, but sh happened after that. anything about Staff maintained that she hpermission to make the shelter.  On 11/9/23 at 10:45 hthe SW said that the the homeless shelter Afterwards, she mad arrangements. She sivery upset shelter repabout Resident #1 ar heart attack." They simply they could see what sher that they could not her behaviors and magoals and she wante questioned about if simedical information whomeless person off a shelter with their mas that is what they could a discharge checklist they can go down the hitting on the plannin 24-hour notice challe get the transportation conversation with Resident #1.	needs, she responded that Resident #1 could use a I Director of Nursing walker to take with her but t. She said that after sion to the shelter, she called e did not know what She denied knowing I or cigarettes. She had Resident #1's he arrangements to go to  AM during a telephone call, Administrator reached out to to ask about admitting her. e the transportation aid that she got a call from a presentative the next day had said that she "faked a ent her to the hospital, and she was like. The SW told but take her back because of anipulation. She met all her d to go to there. When he sent Resident #1's with her, she replied no, as a the street did not come into edical diagnosis information. do.  PM the SW said that they put ton the wall in her office so e list and make sure they are g points. She said the nged her with the need to	F6					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	COMPLETE	(X3) DATE SURVEY COMPLETED	
		165323	B. WING _		C 11/20/2	2023
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		.020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE CO HE APPROPRIATE	(X5) DMPLETION DATE
F 622	Continued From pag	e 48	F	622		
	4-hour notice. Reside	rge sooner as they had a ent #1 reported she was fine er because then her sister and get her.				
	AM, revealed that the time without Residen When the SW made chose the 4-hour pic works for me." They	any, dated 10/25/23 at 7:28 e SW called for a ride at that t #1 in the room with her. the arrangements, she k-up time and said "that finalized the arrangements ny found a driver, they would				
	transportation compa offer the 4-hour picku such as going to hos	PM a representative for the any said that they usually only up option for an emergency; pital or an important y usually did a 48-hour				
	Nurse (RN), said that discharge the Adminity 7-day supply of medit with Resident #1. East went around to say go and staff. Later that in that she only had a house to together and packed #1 expressed that she kicking her out. Staff that they had a plant very abruptly. Staff North that Resident #1 were	• •				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C <b>11/20/2023</b>	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	I	11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	Continued From page	ge 49	F 6	22			
	Staff, said that on the loaded up the remain belongings in her perthem to the shelter. Came with a very small her items in that Resident #1 pack her angry, crying, and skicked her out. She someone above the was happening. She Resident #1 items as	is PM, Staff H, Housekeeping the morning of 10/25/23, she inder of Resident #1's the transportation provider mall car and they could not get vehicle. As she helped the things, she appeared very that she felt the facility kept asking to speak to a Administrator about what the got to the shelter with the tabout 1:30 PM that day.					
	called back and said company just dropp shelter with no paper said they did not typ hospital or nursing know what level of a they can determine they can handle the PM the transportation linitially, the cab drive house intended for The driver did not keep they would not accept the facility, who told homeless shelter. So then she had to lear daughter worked the called 911 due to Reand unstable around 6:15 AM on 10/26/2 soiled back at the sclean up and she taked they would not accept they would not accept the she had to lear daughter worked the called 911 due to Reand unstable around 6:15 AM on 10/26/2 soiled back at the sclean up and she taked they would not accept they would not accept they worked they worked they worked they would not accept they would not acc	AM Shelter Staff 1 (SS1) d that the transportation and Resident #1 off at the enwork and no phone call. She bically accept residents from a mome that way. They need to care the resident required so if they are appropriate or if arm. On 10/25/23 around 1:00 on company dropped her off. Wer dropped her off at a safe domestic violence victims. In a safe domestic violence victims. They there is a safe domestic violence victims. They called a safe domestic violence victims. They called a safe domestic violence victims. They called a safe domestic violence victims. They safe her safe and we early that day. Her are in the afternoon and she are in the afternoon and she are in the afternoon. At the safe hospital returned her helter. They got her a room to alked to a friend on the phone. In the 10/26/23, Resident #1's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIF 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -		ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	not know what happe to get too involved in situations once they the facility made her	ee 50  ed her up. She said she did ened from there. They try not the resident's lives or leave the shelter. She said very upset for just dropping but first having a consultation	F	622			
	on her level of need. children here" and do did call and talk to the not make the arrange	She explained that "we have o not have nursing staff. She e SW who said that she did ements and indicated that Resident #1 back because					
	fact that no one talked before Resident #1 staid that when they conspital, they put the #1 showed up she chinclude her. SS2 call next day and talked to SS1 was very sure of manager, they all staid who is on the list. What their door, she told where they sent her.	AM SS1 that she knew for a and to Shelter Staff 2 (SS2) howed up at their door. She get residents from a facility or m on a list. When Resident necked the list, which did not led back to the facility the loo the SW but not before. If that because she is the lay on top of who is calling and linen Resident #1 showed up them that she did not know She said that they will never the facility ever again or with					
	day she talked to any day that Resident #1 They write down thei computer and they he contacted them regathere. Resident #1 wabout the driver becawith the facility. Origi	PM SS2 said that the first yone at the facility was the showed up at their door. It notes or document on the lave no notes that someone rding Resident #1 coming as at the door, concerned lause he was on the phone mally, he went to the wrong lid not know what to do with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
						C 1 <b>1/20/2023</b>	
	NAME OF PROVIDER OR SUPPLIER  CORRECTIONVILLE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 622	Resident #1 got there Resident #1 could be shortness of breath. In holding up the driver, when they started un things and said that it SS2 said that Reside everything. SS2 talket telling her about Reside not know if they could not take he that they could not take he that they did not know responded that she wof that. Staff 2 started non-emergent care to seemed so unstable, medications, they are on their own. Staff 2 there before, it was a did not have a record. The Encounter Note signed by the Advance Practitioner (NP) on reflected that Reside 10/24/23. At that time stated that she had a getting her an appoin Resident #1 told her in 1-2 days, as the state being inappropriate we planned to leave and for 6 months. The prothe facility on 10/25/2 planned to discharge.	SW called back just after and SS2 told her that arely walk, shook, and had Resident #1 worried about SS2 recalled her surprise loading all of Resident #1's hey could only allow 2 bags. In the had a TV and and to the SW on the phone ident #1 not stable and she would take care of her there, because of her behaviors are back. She told the SW or about her coming, the SW or about her coming, the SW or as sure someone took care of the intake and later called to pick her up because she she did come with some are responsible for taking them as aid if Resident #1 stayed long time ago because she of her being there.  In the intake and later called are pick her up because she are allowed as a side of her being there.  In the intake and later called are pick her up because she are allowed as a side of her being there.	F 6	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING	B. WING		C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		1116 EA	ADDRESS, CITY, STATE, ZIP CODE ST HIGHWAY 20 ECTIONVILLE, IA 51016	1 11/	20/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	elevated pulse is ove on 11/9/23 included the blood pressure consider. 10/17/23 at 4:14 Please. 10/18/23 at 3:17 Please. 10/19/23 at 2:23 Please. 10/19/23 at 2:23 Please. 10/24/23 at 4:33 PM facility and wrote the auxiliary and wrote that lowers pulse) du Complete lipids, color comprehensive metal stimulating hormone at the auxiliary here and the auxiliary and the auxil	Summary and Pulse (HR, an r 100) Summary reviewed he following results (low dered to be below 90/60): M 89/60, HR 112 M 96/62 M 84/55 HR 112 With Physician Note dated reflected the NP came to the following new orders: ne (hypertension medicine) (hypertension medicine) (hypertension medicine) MG (hypertension medicine) MG (hypertension medicine) mplete blood count (CBC), polic panel (CMP), thyroid (TSH), and a hemoglobin asure your blood sugars bs, then repeat in 6 months.  10/24/23 at 4:22 PM armacist noting that hidine should not happen sider tapering gradually and hypertension.  With Physician Note dated andicated that the Pharmacy ation of clonidine should not to rebound hypertension.	F	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP COL 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	from the NP to dischar and treatment orders and treatment orders. The Orders - Adminis at 10:02 AM indicate receive her dressing she discharged home. The Discharge Sumr PM identified that Rehomeless shelter on refused to provide a preferred pharmacy overbal agreement of items at discharge. The Order Note date NP gave a new ordering daily instead of don 11/14/23 at 10:04 a clinical concern of a hypertension with an Pharmacist recomme with monitoring. She to the medication she day blood pressure in The Clinical Physicial clonidine 0.2 milligrated discontinued on 10/2 On 11/14/23 at 10:42 Nurse (RN), said that	received a telephone order arge with current medication to the homeless shelter.  Stration Note dated 10/25/23 d that Resident #1 did not change or lab work because e.  In any dated 10/25/23 at 12:00 sident #1 discharged to the 10/25/23. Resident #1 primary care physician or a upon discharge. She gave an accurate account of her he facility notified Resident d lawyer of her discharge.  In any dated 10/25/23 at 12:00 sident #1 primary care physician or a upon discharge. She gave an accurate account of her he facility notified Resident d lawyer of her discharge.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.  In any dated 10/25/23 at 1:59 PM, the roto decrease clonidine to 0.1 iscontinuing.	F 6	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING		1	C 1/20/2023	
NAME OF PROVIDER OR SUPPLIER  CORRECTIONVILLE SPECIALTY CARE				STREET ADDRESS, CITY, STATE, ZIP ( 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	(DON) stated that silist of medications the upon discharge.  On 11/14/23 at 9:00 Nursing (RDON) said Resident #1's dischargave her a list of he Plan, and a summan while she went through Resident #1, the Add the room. Resident #1 did her and she had offed grievance but she was maintained that they 10/9/23. Resident #1 the transfer. She said up, Resident #1 said could only have 3 but the SW disagreed with would take all her the 11/15/23 at 11:08 Al (DON) said that she discontinued Reside pharmacy recomme abruptly. She agree pressure (BP) need medication change, discharge due to he the discharge activities She said that she discontinued Reside pharmacy recomme abruptly. She agree pressure (BP) need medication change.	AM the Regional Director of id that she assisted with arge. She maintained that she remedication, diagnoses, Care by of her stay. She said that ugh the discharge with ministrator poked her head in #1 called her a "bitch" but did ninistrator upset her. She said I not share any concerns with ered her other avenues to file was not interested. She of planned the discharge since 1 knew about it and agreed to id that as they packed things it that she thought that she ags of items at the shelter, but with her, and said that they	F	622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING_			C 1/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		1/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	Continued From page	e 55	F 6	22			
	10/25/23 the most rethe summary include 10/19/23 at 84/55 and minute.	charge Summary dated cent vital signs included in d a blood pressure taken on d a pulse of 112 beats per					
	consulted her with the Resident #1 and that homeless shelter. Sh change in medication from pharmacy to foll	e AM Staff D said that they e discharge planning for she knew about going to the e did not know about the n or the recommendation low up with blood pressure said that ideally, she would					
	have liked to see a sed discharge. If the Resi concerns, they would the receiving entity.	et of vitals on the day of ident #1 status had I arrange for a follow-up with She maintained that the					
	With BP concerns, pe been appropriate for that the resident was her health needs but	nned and safe discharge. erhaps a BP cuff would have the resident to use. She said aware enough to manage when there were medication					
	When asked why the Resident #1 or why the her for a couple of date.	charge it can be concerning. facility rushed to discharge hey did not wait to monitor ays, Staff D expressed that					
	l •	discharge. She added that angements made it seem uld not control that.					
	revised December 20 transferred or dischard document the details in the medical record appropriate informaticare facility or provide	on to the receiving health er.					
		te transfer or discharge for essary for the resident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C <b>20/2023</b>
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016		20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660 SS=D	b. The resident's heal that the resident no los services. c. The resident's clinic endangered the safet d. The resident's clinicendangers the health e. The resident failed appropriate notice. f. Facility ceases to on Discharge Planning FCFR(s): 483.21(c)(1)(1)(1)(2)(2)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	y cannot meet their needs. Ith improved significantly so onger needs the care or  cal or behavioral status y of individuals in the facility. cal or behavioral status of individuals in the facility. to pay after reasonable and perate. Process (i)-(ix)  rge Planning Process elop and implement an anning process that focuses harge goals, the preparation we partners and effectively st-discharge care, and the eading to preventable cility's discharge planning sistent with the discharge .15(b) as applicable and- charge needs of each and result in the charge plan for each evaluation of residents to require modification of the discharge plan must be to reflect these changes. sciplinary team, as defined	F 66	22		
	developing the discha (iv) Consider caregive and the resident's or	er/support person availability				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		165323	B. WING		C 11/20/2023	
	NAME OF PROVIDER OR SUPPLIER  CORRECTIONVILLE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	111/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 660	discharge needs.  (v) Involve the reside representative in the discharge plan and in resident representati  (vi) Address the reside treatment preference (vii) Document that a about their interest in regarding returning to (A) If the resident indot to the community, the referrals to local confappropriate entities in (B) Facilities must up comprehensive care appropriate, in responsive from referrals to local appropriate entities.  (C) If discharge to the to not be feasible, the made the determinate (viii) For residents where the same the determinate (viii) For residents where the same the data is available, the post-acute care is assessment data, data data on resource used the resident's goals of preferences.	ent and resident development of the inform the resident and we of the final plan. dent's goals of care and is. resident has been asked receiving information the community. dicates an interest in returning e facility must document any react agencies or other hade for this purpose. It contact agencies or other hade to information received I contact agencies or other e community is determined e facility must document who ion and why. The are transferred to another harged to a HHA, IRF, or ts and their resident lecting a post-acute care that includes, but is not IRF, or LTCH standardized data, data on quality on resource use to the extent The facility must ensure that	F 60	60		

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		165323 B. WING			C 11/20/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 660	record, the evaluation needs and discharge evaluation must be diresident's representation information must be it discharge plan to facto avoid unnecessary discharge or transfer. This REQUIREMENT by:  Based on clinical recistaff and residents are failed to meet a residing discharge planning for Resident #1 was discallegations of abuse shelter that was unawand could not meet he facility reported a cer.  Findings include:  Resident #1's Minimulassessment dated 9/Interview for Mental Sindicating intact cognize reflected that Reside Resident #1 required person for transfers, personal hygiene. The frequently incontinent continent of bowel. To disorder of the kiding hypertension (high blimellitus, anxiety, dep Stress Disorder (PTS of upper lobe (lung care).	ds, and include in the clinical of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident nocorporated into the illitate its implementation and or delays in the resident's for is not met as evidenced cord review, interviews with and policy review the facility ent's needs related to perform the second about the analysis of 3 residents reviewed. Charged abruptly after and was sent to a homeless ware that she was coming er medical needs. The assus of 30 residents.  Impulsion Data Set (MDS) 24/23 identified a Brief Status (BIMS) score of 14, ition. The assessment and #1 did not have behaviors. Ilmited assistance from one dressing, toilet use, and the MDS listed Resident #1 as to furine and always the MDS included diagnoses	F 6	60			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE	•	STREET ADDRESS, CITY, STATE, ZIP CO 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	•		
(X4) ID PREFIX TAG			ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 660	dated 10/3/23: a. Resident #1 plann Goal listed that Resit to the community. b. Activities of daily I Interventions directe independently providuse, and transfers. c. Resident #1 is ind Interventions reflecte front wheel walker.  A Social Service note that the Social Work Case Worker and Reincluded that Reside Resident #1 claimed only advocate. The different options as a Resident #1 preferre she had a better chason. The note lacked discharge.  On 11/6/23 at 2:13 P when she reported hemembers, somehow around. Due to this set the facility any more. Administrator came is	ded the following Focuses  led to rehab to home. The dent #1 would transition back living (ADLs). The d that Resident #1 could de her own hygiene, toilet  ependent in the facility. The ed that Resident #1 used a  le dated 10/10/23 indicated er met with Resident #1's esident #1. The discussion int #1 had no family support. her youngest son as her conversation listed two discharge options, but d the homeless shelter as lince with reuniting with her d a planned date for  le M, Resident #1 said that her abuse to a couple of staff they twisted the story she did not trust anyone at	F	660			
	sexual favors for ciga staff took her outside shared with a couple	ported that she provided arettes. Resident #1 said that to to have cigarettes, and she to fithem. Staff I sexually buld not remember the date					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165323	B. WING		11	C / <b>20/2023</b>	
	ROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016		720720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 660	perform oral sex on hiplanning her discharge told her that she plans so her son could comofferred a homeless secould not go there dure felt like the facility kic lies told about her.  On 11/8/23 at 11:12 A reported the transfer homeless shelter as a from there per her life always had a goal to her son. When asked shelter the level of new the shelter, she SW continued by exp "behaviors" related to follow through. When #1's level of medical in the the walker. The Regional arranged to get her a she wanted to get out Resident #1's admissional arranged to get her a she wanted to get out Resident #1's admissional arranged to get her a she wanted to get out Resident #1's admissional arranged to get her a she wanted to get out Resident #1's admissional arranged to get her a she wanted to get out Resident #1's admissional arranged to get her a she wanted to get out Resident #1's admissional arranged to get her a she wanted to get out Resident #1's admissional that have happened after that. She happened after that the homeless shelter Afterwards, she made the homeless shelter Afterwards and homeless shelter Afterwa	to his car and made her im. Resident #1 said when te, the Social Worker (SW) and to help her find housing e and live with her. The SW shelter as option but her son to his age. She said she ked her out because of the the worker (SW) of Resident #1 to the appropriate as she came estyle choice. Resident #1 discharge and reunite with if she told the staff at the ted before sending Resident replied "yes and no." The ressing Resident #1's impulsivity and lack of inquired about Resident meeds, she responded that Resident #1 could use a Director of Nursing walker to take with her but it. She said that after ion to the shelter, she called the did not know what She denied knowing or cigarettes. She had Resident #1's he arrangements to go to the work about admitting her.	F 66	60			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		165323	B. WING _		11/20/20	23
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	111120120	20
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COM	(X5) PLETION DATE
F 660	about Resident #1 and heart attack." They so they could see what her that they could in her behaviors and migoals and she wanted questioned about if somedical information in homeless person official as shelter with their mandal As that is what they concorrectly and on the planning 24-hour notice challed get the transportation conversation with Resident on Friday or Monday being okay to dischard 4-hour notice. Reside with it, as it was bette did not have to come A review of a voice mit transportation compared AM, revealed that the time without Resider When the SW made chose the 4-hour pick works for me." They and once the compared to 11/14/23 at 12:12	presentative the next day and said that she "faked a ent her to the hospital, and she was like. The SW told of take her back because of anipulation. She met all her d to go to there. When she sent Resident #1's with her, she replied no, as a the street did not come into redical diagnosis information. do.  PM the SW said that they put ton the wall in her office so the list and make sure they are regorded by a said the reged her with the need to her she questioned about her rege sooner as they had a resident #1 about discharge to she questioned about her rege sooner as they had a rent #1 reported she was fine the and get her.  Becording from the recording from the recording from the resident #1 in the room with her. The arrangements, she k-up time and said "that finalized the arrangements my found a driver, they would be of arrival.	F 6	60		
	transportation compa	PM a representative for the any said that they usually only up option for an emergency;				

l ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , ,			(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C <b>11/20/2023</b>	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		11/20/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 660	Continued From pa	ge 62	F 6	60			
		spital or an important ey usually did a 48-hour					
	Nurse (RN), said ea went around to say and staff. Later that that she only had a together and packe #1 expressed that s her out. Staff N said had a plan for disch abruptly. Staff N rep that Resident #1 we without nursing sen needed monitoring her hypertension m On 11/9/23 at 12:15 Staff, said that on the loaded up the reman	and Staff N, Registered arly that morning, Resident #1 good bye to other residents morning when she found out half hour to get everything d she started to cry. Resident the felt like the facility kicked d that she understood that they harge but it came very corted that she had concerns ent to a homeless shelter vices especially when she as the provider just changed edication.  5 PM, Staff H, Housekeeping he morning of 10/25/23, she inder of Resident #1's ersonal vehicle and drove					
	them to the shelter. came with a very sr all her items in that Resident #1 pack h angry, crying, and s kicked her out. She someone above the was happening. Sh Resident #1 items a	The transportation provider mall car and they could not get vehicle. As she helped er things, she appeared very said that she felt the facility kept asking to speak to a Administrator about what e got to the shelter with at about 1:30 PM that day.					
	called back and sai company just dropp shelter with no pape said they did not typ	AM Shelter Staff 1 (SS1) d that the transportation led Resident #1 off at the lerwork and no phone call. She loically accept residents from a loome that way. They need to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		165323	B. WING			11/	20/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CORRECT	ONVILLE SPECIALTY	CARE		11	116 EAST HIGHWAY 20		
CONTRECT	TOTALLE OF ESTALT	CARL		С	ORRECTIONVILLE, IA 51016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From paknow what level of they can determine they can handle the PM the transportation Initially, the cab driventh house intended for The driver did not kethey would not accept the facility, who told homeless shelter. Steen she had to lead aughter worked the called 911 due to Rand unstable aroun 6:15 AM on 10/26/2 soiled back at the sclean up and she taken and picture to get too involved is situations once they the facility made he off Resident #1 with on her level of need children here" and did call and talk to the too the too involved is the too involved is situations once they the facility made he off Resident #1 with on her level of need children here" and did call and talk to the too the too involved is the too involved is situations once they the facility made he off Resident #1 with on her level of need children here" and did call and talk to the too involved is and talk to the too involved is situations once they the facility made here.  On 11/13/23 at 7:26 fact that no one talk before Resident #1	ge 63 care the resident required so if they are appropriate or if em. On 10/25/23 around 1:00 on company dropped her off. Wer dropped her off at a safe domestic violence victims. In oww hat to do with her when ept her there, so, they called a them to take her to the early that day. Her ere in the afternoon and she esident #1 shaking, falling, d 4:00 PM in the afternoon. At 23 the hospital returned her helter. They got her a room to alked to a friend on the phone. In the 10/26/23, Resident #1's exed her up. She said she did bened from there. They try not in the resident's lives or a leave the shelter. She said in very upset for just dropping thout first having a consultation of the SW who said that she did gements and indicated that Resident #1 back because		660			
	#1 showed up she include her. SS2 ca	em on a list. When Resident checked the list, which did not illed back to the facility the to the SW but not before.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465202	B. WING				0
		165323	B. WING _			11/	20/2023
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CORRECT	IONVILLE SPECIALTY O	CARE		11	16 EAST HIGHWAY 20		
001111201				C	ORRECTIONVILLE, IA 51016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)  DEFICIENCY)			(X5) COMPLETION DATE			
F 660	Continued From page	e 64	F 6	660			
	manager, they all stag who is on the list. Wh at their door, she told where they sent her.	f that because she is the y on top of who is calling and hen Resident #1 showed up them that she did not know She said that they will never facility ever again or with					
	day she talked to any day that Resident #1 They write down their computer and they had contacted them regar there. Resident #1 was about the driver becawith the facility. Origin place first and then dher things. Then the Resident #1 got there Resident #1 could be shortness of breath. It holding up the driver, when they started unthings and said that the SS2 said that Reside everything. SS2 talket telling her about Residid not know if they could not take he that they did not know responded that she wof that. Staff 2 started non-emergent care to seemed so unstable, medications, they are	PM SS2 said that the first one at the facility was the showed up at their door. In notes or document on the ave no notes that someone rding Resident #1 coming as at the door, concerned tuse he was on the phone hally, he went to the wrong id not know what to do with SW called back just after a and SS2 told her that trely walk, shook, and had Resident #1 worried about SS2 recalled her surprise loading all of Resident #1's hey could only allow 2 bags. Int #1 he had a TV and and to the SW on the phone dent #1 not stable and she ould take care of her there, because of her behaviors her back. She told the SW or about her coming, the SW or as sure someone took care of the intake and later called to pick her up because she she did come with some a responsible for taking them said if Resident #1 stayed					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	165323	B. WING				C / <b>20/2023</b>
	CARE	-1	1116 EA	ST HIGHWAY 20	<u>, , , , , , , , , , , , , , , , , , , </u>	20/2020
SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
did not have a record On 11/14/23 at 9:00 Nursing (RDON) said Resident #1's dischat gave her a list of her Plan, and a summary while she went throut Resident #1, the Adr the room. Resident #1 not say why the Adm that Resident #1 did her and she had offe grievance but she wa maintained that they 10/9/23. Resident #1 the transfer. She said up, Resident #1 said could only have 3 bat the SW disagreed wi would take all her thi  On 11/15/23 at 11:08 (DON) said that she discontinued Reside pharmacy recommer abruptly. She agreed pressure (BP) neede medication change. discharge due to her the discharge activity She said that she did consulted nursing to they should delay Re  The Transfer or Disc	AM the Regional Director of that she assisted with rge. She maintained that she medication, diagnoses, Care of of her stay. She said that gh the discharge with ministrator poked her head in the called her a "bitch" but did inistrator upset her. She said not share any concerns with red her other avenues to file as not interested. She planned the discharge since knew about it and agreed to did that as they packed things that she thought that she gs of items at the shelter, but th her, and said that they ngs.  AM The Director of Nursing did not know that they not that the medicine of that Resident #1's blood did monitoring after the she did not assist with the not being available when all of and decisions happened. If not know if anyone see about any reason why esident #1's discharge.	F	660			
transferred or discha	rged, the facility must					
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page did not have a record On 11/14/23 at 9:00. Nursing (RDON) said Resident #1's dischat gave her a list of her Plan, and a summary while she went throu Resident #1, the Adm the room. Resident # not say why the Adm that Resident #1 did her and she had offe grievance but she wa maintained that they 10/9/23. Resident #1 the transfer. She said up, Resident #1 said could only have 3 ba the SW disagreed wi would take all her thi  On 11/15/23 at 11:08 (DON) said that she discontinued Resider pharmacy recommer abruptly. She agreed pressure (BP) neede medication change. Si discharge due to her the discharge activity She said that she did consulted nursing to they should delay Re  The Transfer or Discrevised December 20 transferred or discha	TONVILLE SPECIALTY CARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	TONVILLE SPECIALTY CARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65 did not have a record of her being there.  On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge. She maintained that she gave her a list of her medication, diagnoses, Care Plan, and a summary of her stay. She said that while she went through the discharge with Resident #1 did not share any concerns with her and she had offered her other avenues to file grievance but she was not interested. She maintained that they planned the discharge since 10/9/23. Resident #1 knew about it and agreed to the transfer. She said that as they packed things up, Resident #1 said that she thought that she could only have 3 bags of items at the shelter, but the SW disagreed with her, and said that they would take all her things.  On 11/15/23 at 11:08 AM The Director of Nursing (DON) said that she did not know that they discontinued Resident #1's abruptly and that the pharmacy recommended not to stop the medicine abruptly. She agreed that Resident #1's blood pressure (BP) needed monitoring after the medication change. She did not assist with the discharge activity and decisions happened. She said that she did not know if anyone consulted nursing to see about any reason why they should delay Resident #1's discharge.  The Transfer or Discharge Documentation policy revised December 2016 directed that if a resident transferred or discharged, the facility must	TONVILLE SPECIALTY CARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65 did not have a record of her being there.  On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge. She maintained that she gave her a list of her medication, diagnoses, Care Plan, and a summary of her stay. She said that while she went through the discharge with Resident #1, the Administrator poked her head in the room. Resident #1 called her a "bitch" but did not say why the Administrator upset her. She said that Resident #1 did not share any concerns with her and she had offered her other avenues to file grievance but she was not interested. She maintained that they planned the discharge since 10/9/23. Resident #1 knew about it and agreed to the transfer. She said that as they packed things up, Resident #1 said that she thought that she could only have 3 bags of items at the shelter, but the SW disagreed with her, and said that they would take all her things.  On 11/15/23 at 11:08 AM The Director of Nursing (DON) said that she did not know that they discontinued Resident #1's abruptly and that the pharmacy recommended not to stop the medicine abruptly. She agreed that Resident #1's blood pressure (BP) needed monitoring after the medication change. She did not assist with the discharge due to her not being available when all the discharge activity and decisions happened. She said that she did not know if anyone consulted nursing to see about any reason why they should delay Resident #1's discharge.  The Transfer or Discharge Documentation policy revised December 2016 directed that if a resident transferred or discharged, the facility must	TONVILLE SPECIALTY CARE  TONVILLE SPECIALTY CARE  SUMMANY STATEMENT OF DEFICIENCES (EACH DEFICIENCES)  (EACH DEPICIENCY WISE TE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65 did not have a record of her being there.  On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge with ear and she had offered her other avenues to file grievance but she was not interested. She maintained that they planned the discharge since 10/9/23. Resident #1 said that as they packed things up, Resident #1 said that as they packed things up, Resident #1 said that she shoult and agreed to the transfer. She said that they would take all her things.  On 11/15/23 at 11:08 AM The Director of Nursing (DON) said that she did not know that they discontinued Resident #1's abruptly and that the pharmacy recommended not to stop the medicine abruptly. She agreed that Resident #1's blood pressure (BP) needed monitoring after the medication change. She did not assist with the discharge due to her not being available when all the discharge activity and decisions happened. She said that she did not know if anyone consulted nursing to see about any reason why they should delay Resident #1's discharge.  The Transfer or Discharge Documentation policy revised December 2016 directed that if a resident transferred or discharged, the facility must	TONVILLE SPECIALTY CARE  10NVILLE SPECIALTY CARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY BY THE REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 65  did not have a record of her being there.  On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge. She maintained that she gave her a list of her medication, diagnoses, Care Plan, and a summary of her stay. She said that while she went through the discharge with Resident #1 did not share any concerns with her and she had offered her other avenues to file grievance but she was not interested. She maintained that they planned the discharge since 10/9/23, Resident #1 and that they planned the discharge since 10/9/23, Resident #1 fallers at the shelter, but the SW disagreed with her, and said that they would take all her things.  On 11/15/23 at 11:08 AM The Director of Nursing (DON) said that she did not know that they pharmacy recommended not to stop the medicine abruptly. She agreed that Resident #1's blood pressure (BP) needed monitoring after the medication change. She did not assist with the discharge due to her not being available when all the discharge activity and decisions happened. She said that she did not know if anyone consulted nursing to see about any reason why they should delay Resident #1's discharge.  The Transfer or Discharge Documentation policy revised Docember 2016 directed that if a resident transferred or discharged, the facility must

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C <b>11/20/2023</b>	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 660	Continued From page in the medical record	, and communicate	F 60	60			
F 835 SS=E	care facility or provide Administration	on to the receiving health er.	F 83	35			
	enables it to use its re efficiently to attain or practicable physical, well-being of each rest This REQUIREMENT by: Based on interviews facility failed to ensur administration service abuse, the administrationallegations to the prodischarged the reside	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  T is not met as evidenced and record review the ethey provided adequate es. Upon allegations of atter failed to conduct a					
	Interview for Mental S indicating intact cogn reflected that Resider Resident #1 required person for transfers, of personal hygiene. The frequently incontinent continent of bowel. The of disorder of the kidr	24/23 identified a Brief Status (BIMS) score of 14, ition. The assessment nt #1 did not have behaviors. limited assistance from one dressing, toilet use, and e MDS listed Resident #1 as of urine and always ne MDS included diagnoses					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165323	B. WING		11/20/2	023
	OVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016	,20/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE COM	(X5) MPLETION DATE	
	Stress Disorder (PTS of upper lobe (lung of indicated that Reside pain.  On 11/8/23 at 10:48 (DA), said that on the she waited outside on her shift and sat with Resident #1 told her Aide (CNA), bought her phone and transt Cash App. After this, he took her to his call perform oral sex on her they were drinking all anyone to know about then stopped over ar when Resident #1 to from Staff I, but she so she could not sho Resident #1 trembled story and expressed he knew she told anyone to her should not sho Resident #1 trembled story and expressed he knew she told anyon 11/8/23 at 10:32 evening of 10/23, Restaff A and when she at her and asked "cashook her head "yes tell her that Staff I see masturbating. They are port this to the Admat around 10:00 AM the Administrator.	AM, Staff A, Dietary Aide evening of 10/23/23 while f the facility for a ride after Resident #1 on the patio. that Staff I, Certified Nurse her cigarettes, then he took ferred money into his own Resident #1 told Staff A that one night and forced her to him. Resident #1 said that cohol and she did not want at it. Staff F, Nurse Aide (NA), and entered the conversation led them that she had a video needed to charge her phone, we them. She said that did when she told them the fear of what he might do if	F 83	5		

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		165323	B. WING _			C 11/20/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016	I	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	for Resident #1, and his phone. The Adm Staff I come into her showed her the Casi for \$10.00, and she showed her the Casi for \$10.00, and she shoulding. When aske sex, the Administrator Resident #1 about progrettes, but she didented any sexual and acknowledged that his smoke but denied ar Administrator said the stating that it was fall the signed by Resident #1 Administrator confrounce accused her of provicting are the signed by Resident #1 Administrator confrounce accused her of provicting are the signed by Resident #1 by the allegations, anything so vile. She the hand-written note forced sexual acts.  The Care Plan Focus Resident #1 planned listed that Resident #1 planned listed that Resident #1 planned listed that Resident #1 when Resident #1 wrigarettes, he made	with Staff I buying cigarettes that he used a Cash App on inistrator said that she had office that morning. He hap receipt on his phone suspended him from the d about the allegations of or said that she confronted roviding sexual favors for enied it. She said that Staff I ctivity with Resident #1. He had considered to the said that had said that Staff I ctivity with Resident #1.	F8	35		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165323	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER	CARE		STREET ADDRESS, CITY, STATE, Z 1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 5101		20/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	•	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	history of making falsevents to gain attent separated Staff I from to purchasing cigare investigation statemed the staff member who history of making alled that many staff and resident interviews, and a residen	that it occurred. The ed that Resident #1 had a se stories and exaggerating ion. The Administrator in the facility and he admitted ttes for Resident #1. The ent included comments that to reported the abuse, had a regations against Staff I, and residents at the facility had a se allegations against African rement indicated the facility rement on 10/24/23.  Eluded an undated list of the investigation lacked staff sident assessment.  AM a representative from the hrough the files to see if they be facility on 10/24 or 10/25 are with Resident #1 as the orted that they did not have collity regarding abuse  aM, Staff I said that on alle had him working a 6a-6p AM, the Administrator called	F	835			
	cigarettes." The Adm ever took Resident # cigarettes and he tol he chose to leave the because he would no	ninistrator asked him if he f1 in his car to go purchase d her that he did not. He said e facility on 10/24/23 ot feel comfortable working aid that he went to a sister					

OLIVILITO I OIT MEDIO/IITE G IV	ILDIO/ (ID OLI (VIOLO				OIVID ITC	<del>7. 0000 000 1</del>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			_		(	С
	165323	B. WING				20/2023
NAME OF PROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORRECTIONVILLE SPECIALTY CA	ADE		11	116 EAST HIGHWAY 20		
CORRECTIONVILLE SPECIALITY CA	ANE		С	ORRECTIONVILLE, IA 51016		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
denied having any kind Resident #1 and said to little bit on the patio. He messages and said that anything wrong with act purchase of cigarettes. he worked in different sometime problem with buying the said that he did not specified were about and did not the interview. He maint Administrator did not be sexual interactions betted things. He thought that of the interaction between Administrator. He said magnetism, I can overestellar worker." He said him to work other shifts mentioned three other shifts after the 24th. He they thought he did son allowed him to continue He reported feeling upsallegations as preposted.  On 11/14/23 at 9:00 AN Nursing said that their "rapid response" phone concern with Resident that most of the converted.	a shift that same day. He do frelationship with hat he would sit with her a seedenied sending her any at he did not feel he did excepting her money for the states and did not have a sings for residents. Staff I send much time with exed if he thought that she sion about their sted what the questions at understand the reason for tained that the ring up or ask about any ween him and Resident #1. In a said that he worked as and learned to record the may have a recording the himself and the "I am keeping my come obstacles I am a do that the company begged as since 10/24/23. He facilities that he completed the did not understand that if mething wrong, why they set and described the erous.  If the Regional Director of leadership team had a	F	835	DEFICIENCY)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165323	B. WING				20/2023
	ROVIDER OR SUPPLIER	CARE	<b>.</b>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	that the Administrator I only made a motion masturbation. The manything about allega activity.  On 11/14/23 at 2:50 F said the rapid responinformation, or accura Administrator to dete said that had they knowled have made different according to an annudated 10/19/22, Staff without her consent of file lacked a correctivindication that the fact with him.  Staff I's timesheet show work with vulnerable facilities on 10/24/23 10/28/23 from 10:19 10/30/23 at 10:01 PM.  The Facility's Job De Administration revise Essential Functions for to operate the facility established company compliance with feder regulations. They wo notifying appropriate transfer either temporassure that staff implements.	sexual innuendos. She said conveyed to them that Staff that simulated seting did not include ations of forced sexual  PM the Regional Manager se team did not get all the ate information from the rmine the next steps. She own all the details, they ferent decisions.  Ital facility survey report I recorded a resident or knowledge. His personal e action form or any sility addressed that incident  owed that he continued to elderly population in their from 2:04 PM - 7:02 PM, PM - 6:14 AM, and on 1 - 6:00 AM.  scription for the position of d April 2018, described the or General Management as in accordance with the policies and procedures in ral, state and local uld assume responsibility for state and local agencies of rary or permanent. They ements programs and and meet the health and	F	835			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		165323	B. WING _		1.	C 1/ <b>20/2023</b>	
NAME OF PROVIDER OR SUPPLIER  CORRECTIONVILLE SPECIALTY CARE				STREET ADDRESS, CITY, STATE, ZIP CODE  1116 EAST HIGHWAY 20  CORRECTIONVILLE, IA 51016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETIC DATE		